previous Israeli study of 5803 AMI pts in 1981–1983 [Prethrombolytic era (PTE)].

Results: Pts in the TE with PAF (n = 255) were older and had worse risk profile than those without PAF (n = 2611). PAF in the TE was independently associated with increased 30-day [odds ratio (OR) 1.32, 95% CI 0.92–1.87] and 1-year [relative risk (RR) 1.33, 95% CI = 1.05–1.68] mortality. Stroke occurred significantly more in pts with than without PAF (3.9 vs 0.6%, OR 4.6, 95% CI 1.90–10.8), and was related to ventricular, but not atrial, thrombus. The incidence of PAF (8.9 and 9.9%), 30-day (25.1 and 27.6%) and 1-year (38.4 and 42.5%) crude mortality rates of pts with PAF were similar in the TE and PTE, although PAF in the TE occurred in older and sicker pts. After multivariate adjustment, PAF in the TE was associated with significantly lower 30-day (OR 0.64, 95% CI 0.44–0.94) and 1-year (RR 0.69, 95% CI 0.54–0.88) mortality compared with PTE counterparts.

Conclusions: AMI pts who develop PAF in the TE have significantly worse short- and long-term prognosis than pts without PAF, and most likely deserve early and aggressive treatment. The better adjusted outcome of pts with PAF in the TE seemingly reflects improved current management of AMI.

1109-129 Pulmonary Artery Catheterization and Mortality in Acute Myocardial Infarction

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Background: The frequency and efficacy of hemodynamic monitoring by pulmonary artery catheterization in MI are unknown.

Methods: Using the comprehensive NY State Department of Health hospital administrative data set (SPARCS), we identified all patients (pts) admitted with MI in NY State in 1995. Demographic and clinical data and hospital outcomes were compared between pts with (N = 1520, 4% of all pts) and without (N = 35167) PAC.

Results: PAC pts were older, had more comorbidities, and had a higher incidence of shock, CHF, COPD, valvular disease, anterior MI and admission to a teaching hospital. In multivariable analysis, controlling for race, sex, hospital, age, Comorbidity Index, CHF, type of MI, shock, HTN, DM and ventricular arrhythmia, PAC pts had a 2.4 fold increase in mortality (95% CI 2.1–2.8).

	With PAC	Without PAC
CHF †	67%	34%
Shock †	27.2%	2.9%
Comorbidity Index †	3.0 ± 1.7	2.3 ± 1.5
Adjusted Mortality †	19.9%	9.9%

† = p < 0.05

Conclusions: Pulmonary artery catheterization 1) is used in 4% of pts with MI and is more common in pts admitted to teaching hospitals, 2) is used in higher-risk, sicker pts, and 3) remains associated with increased mortality despite controlling for clinical risk factors and comorbidities. Studies of the indications and efficacy of PAC in MI are warranted.

1109-130 Feasibility of Direct Discharge From the Coronary/Intermediate Care Unit After Acute Myocardial Infarction

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Background: This investigation was designed to determine the impact of direct discharge from coronary/intermediate care unit (CCU), without a period of stay on a medical ward following an acute myocardial infarction (AMI). This change in pt. management was implemented following downsizing of available hospital beds resulting from reductions in global health care expenditure. The post discharge course was evaluated by a telephone interview 6 weeks after discharge using a structured questionnaire in 288 consecutive patients (age 62.9 ± 1.07 yrs; range 20–91; M-206, F-82) with AMI discharged alive.

Results: The mode length of CCU stay for all pts was 4.0 days (mean 5.3 ± SEM 0.24 days); 1–2 (9%), 3 (18%), 4 (24%), 5 (15%), 6–7 (18%), ≥8 (16%) days, respectively. Of the 288 surveyed 77 (27%) indicated they had made unscheduled return visits (URV) to a hospital or physicians office; 38 (13%) to emergency, 16 (6%) physician office, and 23 (8%) were readmitted to hospital. Forty-six (46) of 288 (16%) felt that they had been discharged too early. Of the 46 (41%) had URV. Overall 247 of 288 (86%) felt that they received enough information prior to discharge. Of the 288, 250 commented on quality of care; 89% indicated -good to outstanding, 11% indicated -unsatisfactory. There were 6 deaths during the 6 week period post discharge.

Conclusions: Direct discharge from CCU is a feasible and safe strategy resulting in considerable savings. Although 27% of patients made unscheduled return visits, the majority of these occurred beyond 48 hrs of discharge. Thus, delaying discharge with a further stay on a medical ward is unlikely to have made an impact on these return visits.

1110 Angioplasty and Stenting in Acute Myocardial Infarction II

Tuesday, March 31, 1998, Noon–2:00 p.m.
Georgia World Congress Center, West Exhibit Hall Level
Presentation Hour: 1:00 p.m.–2:00 p.m.

1110-149 In-hospital and Late Outcomes Following Primary Stenting in Acute Myocardial Infarction – Comparison With Primary PTCA

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Primary stenting in AMI has the potential to improve patient outcomes compared to primary PTCA. In the PAMI Stent Pilot Study, stenting was performed in 240 consecutive pts with AMI and eligible vessels. The acute and late outcomes in these patients were compared to the 175 pts in the PAMI-1 trial in whom PTCA alone without stenting was performed. PAMI-1 and PAMI Stent patients were well matched for mean age (59.6 vs. 60.5 yrs), female gender (23% vs. 25%), diabetes (13% vs. 15%), cigarette smoking (46% vs. 40%), prior MI (14% vs. 13%), 3VD (19% vs. 21%), and LAD MI (37% vs. 36%) (all p = NS). Outcomes appear in the Table.

In-hospital events	PAMI-1	PAMI Stent	p value
Death or reMI	5.1%	2.1%	0.09
RePTCA infarct artery	4.0%	2.1%	NS
CABG	3.4%	2.9%	NS
Composite endpoint	9.7%	4.6%	0.04
Recurrent ischemia	10.3%	3.8%	0.008
Hospital stay (days)	7.4 ± 3.3	6.2 ± 3.7	0.0004
Cumulative 6 month events			
Death or reMI	8.6%	5.5%	NS
RePTCA infarct artery	18.1%	10.5%	0.03
CABG	10.9%	7.1%	NS
Composite endpoint	28.6%	18.5%	0.02

Conclusions: Performed by experienced AMI interventionalists, primary stenting improves in-hospital outcomes compared to primary PTCA, and may result in a 35% reduction in late adverse events. Large scale, randomized trials comparing primary PTCA to primary stenting in AMI are warranted.

1110-150 Comparison of the Effects of Prolonged Versus Standard Balloon Inflation for Acute Anterior Myocardial Infarction

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Background: Primary gradual and prolonged dilatations cause less arterial trauma with compared with standard dilatations in elective angioplasty. The myocardium may be damaged by a sudden reperfusion. The purpose of this study was to evaluate the impact of prolonged inflation versus standard short dilatations in patients undergoing direct angioplasty.

Methods: We performed a prospective analysis 70 patients with acute anterior myocardial infarction (AMI). One or two prolonged (10 minutes) dilatation was observed in 35 patients using perfusion balloon catheter (PBC group), and the other 35 patients were received two or five standard (1 minute) dilatation using standard balloon catheter (SBC group).

Results: The PBC group was a higher success rate after initial balloon (< 50 residual stenosis) (93.5% vs. 54%; p = 0.0003), less recoil (6% vs. 31%; p = 0.011), and a lower rate of major dissections (0% vs. 14%; p = 0.036) at the acute phase. Therefore, the number of balloons used per angioplasty was 1.1 ± 0.3 balloons in the PBC group, as compared with 1.6 ± 0.6 balloons in the SBC group (P < 0.0001). Regional wall motion improved significantly over the baseline (−2.65 ± 0.48 SD/chord) at the time of the AMI when seen 1 (−2.35 ± 0.81 SD/chord, p = 0.048) and 6 months (−2.20 ± 0.66 SD/chord, p = 0.047) after the infarction in the PBC group, which was not observed in the SBC group. Mismatch of thallium-201 and iodine-123-methyl-p-iodophenyl-pentadecanoic acid SPECT imagings was 33% in the PBC group, as compared with 11% in the SBC group (p = 0.033).

Conclusion: These findings suggested that the primary gradual and prolonged dilatations in direct angioplasty may reduced the initial complications and prevent ventricular remodeling of the infarct zones in AMI.